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Volume 6 | Issue 1

Article 10

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1-1-2009

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## Recommended Citation

Tran, Kimberly (2009) "Examining Conversational Constraints in Vietnamese Patient-Doctor Communication: A Case Study," *XULAnexUS*: Vol. 6 : Iss. 1 , Article 10.  
Available at: <https://digitalcommons.xula.edu/xulanexus/vol6/iss1/10>

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## **Examining Conversational Constraints in Vietnamese Patient-Doctor Communication: A Case Study**

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### **Abstract**

The purpose of this study was to determine the use of conversational constraints among older members of the New Orleans Vietnamese community within the primary healthcare context. A purposive sample of seven Vietnamese male and five Vietnamese female immigrants between the ages of 47 and 80 was interviewed. Conversational constraints were evident in the responses relating to communication with physicians. The respondents emphasized relational conversational constraints such as minimal imposition on the physician's autonomy, prevention of hurting the physician's feelings, and prevention of negative evaluation by the physician. Conversely, task-oriented conversational constraints such as concern for clarity and effectiveness were exhibited indirectly. A secondary finding of this study revealed that constraints were minimal in relation to the manner in which the responses were given to the researcher. This difference can be explained through dimensions of cultural variability such as power distance and self construals.

**Key Terms:** Collectivism, Conversational Constraints, Cultural Variability, Doctor-Patient Communication, Health Care, Vietnamese Community

The Asian American population experienced a 48% increase between 1990 and 2000 (Barnes, Adams & Powell-Griner, 2008). They are a fast-growing ethnic group in the United States who deserves much attention in contexts that are sensitive to cultural differences such as healthcare. Quantitative studies have consistently shown high levels of patient dissatisfaction in the healthcare interactions of Asian Americans compared to other ethnic groups. Respondent perceptions of specific aspects of healthcare interactions, such as the comprehensiveness of care and the physician's sensitivity towards the patient's cultural lifestyle, are all heavily influenced by the quality of their communication experiences with their physicians.

Vietnamese Americans are currently the fifth largest Asian American group in the United States (Southeast Asia Resource Action Center [SEARAC], 2004) and are projected to become the second largest by 2030 (Kaplan et al. , 2003). Some research has been done on Vietnamese culture and the common diseases found among Vietnamese populations in the United States, as

*An earlier version of this paper was presented at the 2008 Xavier Festival of Scholars and the Louisiana Communication Association. The paper received the Top Undergraduate Research Paper Award.*

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well as those in different areas of the world (Asian and Pacific Islander American Health Forum [APIAHF], 2006). However, very little is known about Vietnamese communication behaviors in the physician-patient context. Despite its growing size, the Vietnamese American population has been understudied in the field of healthcare communication.

In 2000, the Vietnamese population in the New Orleans metropolitan area was the 15<sup>th</sup> largest in the United States (Barnes & Bennett, 2002). It is noted for its sense of community. After Hurricane Katrina, the Vietnamese population was one of the first groups to rebuild, despite high stress levels and disordered government guidance (Chiang, 2008). This study focuses on the Vietnamese community, examining the influence of its members' shared culture on communication patterns in the healthcare context.

### **Theoretical Framework**

The style of communication commonly exerted by a specific ethnic group depends on several dimensions of cultural variability. In the broadest sense, cultural variability can be viewed in terms of two extremes: individualism and collectivism (Gudykunst & Lee, 2002). Individualistic cultures put emphasis on the individual's personal goals over others. Conversely, people from collectivistic cultures base their goals on their in-group members (family and close friends) in exchange for loyalty (Hofstede & Bond, 1984). A strong sphere of influence and a certain intimacy are reserved exclusively to members within distinct in-group boundaries (Gudykunst & Ting-Toomy, 1988).

Asian ethnic groups have commonly been identified as collectivistic. They exert conversational constraints in ways such as making indirect requests to avoid imposing on others (Kim & Wilson, 1994). They also exert high power distance (Hofstede & Bond, 1984), which implies an ever-present sense of power difference during a conversation between two people. In addition, they have interdependent self construals, which lead them to act in certain ways based on their relation with their communication partner in a specific context (Markus & Kitayama, 1998). Further, they resort to high context communication, which requires both participants to read each others' minds and to speak indirectly in order to maintain harmony (Hall, 1976).

In the healthcare context, cultural variability acts as a predispositional influence on the patient's communication style (Street, 2003), which may further impact the quality of the physician-patient relationship. According to Kim et al. (2000), indirectness, respect for authority, and accommodation to others are characteristic to the communication style of collectivistic cultures. This communication style leads individuals from collectivistic cultures to express fewer positive beliefs about patient participation and less willingness to be assertive during medical consultations than those from individualistic cultures.

The indirect and accommodating communication style typical of Asian cultures is reflected in the theory of conversational constraints (Kim & Wilson, 1994). Conversational constraints are the guiding motives responsible for selecting certain constraints within one's communication style. They may become barriers to facilitating quality relationships between patients and their physicians, which subsequently affect the quality of care provided by the physician. The theory consists of five main motives that belong to two conflicting broad categories: relationally-oriented and task-oriented. Relationally-oriented constraints include (1)

avoiding hurting the hearer's feelings, (2) minimizing imposition on the hearer, and (3) avoiding negative evaluation by the hearer (Kim & Wilson, 1994). Task-oriented constraints include the (4) importance of clarity and (5) concern for effectiveness. Clarity is important in explicitly expressing the goal of the speaker through the message. Concern for effectiveness refers to the extent to which the speaker successfully achieves a goal through the message (Kim & Wilson, 1994).

## Literature Review

Many studies have provided evidence for the low healthcare ratings of Asian groups compared to other ethnic groups. However, few studies have directly focused on how culture might account for this difference. According to Kandula, Lauderdale, and Baker (2007), limited English proficiency and different health perceptions in diagnosis, medical concepts, and treatments are the two main factors explaining the low self-reported ratings for overall healthcare interactions for Asians as compared to Caucasians and Hispanics. Blendon et al. (2007) found that Asians have high ratings for the American healthcare system but low ratings for medical care received because of discrimination resulting from low English proficiency and difference in cultural background. Results from a study by Meredith and Siu (1995) show that Asians perceive better or equal health status to Caucasians. However, they also report less satisfaction in their healthcare encounters because of insufficient physician interaction. Compared to African Americans and Hispanic Americans, Asian Americans report lower quality interactions, lower levels of cultural sensitivity among physicians, and a lack of appropriate services (Saha, Arbelaez, & Cooper, 2003). Little effort has been directed toward connecting specific demographic information relating to acculturation levels such as education level, English proficiency, and amount of years spent in the States to the low ratings.

Some studies suggest that the rating difference may lie in reasons not directly related to the physician-patient interaction (Haviland, Reise, & Hays, 2003; Kandula et al., 2007; Meredith & Siu, 1995; Ngo-Metzger et al., 2003; Saha et al., 2003). Kandula et al. (2007) explain that the difference in healthcare views may have led Asian representative samples to give lower ratings. For example, many Asians believe in traditional holistic health practices, which may not be implemented by their non-Asian physicians. Ngo-Metzger et al. (2003) reason that the high trust in physicians leads to high expectations for the quality of the interaction, which are sometimes not met by the subjects' standards. Saha et al. (2003) and Meredith et al. (1995) also propose that Asians may have a more negative response tendency resulting from unmet high expectations placed on their physicians.

A few studies focusing specifically on Vietnamese populations outside of Vietnam suggest low acculturation levels as a tentative explanation for their dissatisfaction with their healthcare experiences. A study conducted by the *Australia Association for Research and Education* (2005) provides insight on Vietnamese migrants who have difficulty adapting to a foreign English-speaking country. The difficulties they face in their physician-patient interactions include emotional isolation, linguistic alienation, distrust, and unfamiliar healthcare practices.

McPhee (2002), a bilingual Vietnamese physician in the United States, wrote an article based on his Vietnamese immigrant patients' difficulties of attaining a new understanding of

health conditions and treatments that contradict their culture-influenced views. He also stated that many Vietnamese patients are unaware of their medical issues since they lack preventive care experiences. Along with lack of preventive care, Khuu (1998) described other factors resulting from poverty (e.g. lack of education, literacy, and medical understanding) that contribute to Vietnamese patient behavioral patterns such as non-compliance, use of cheaper alternative medicine, and avoidance of questioning authority. These behaviors express health perceptions prevalent in Vietnam but not in the United States, which translates into a difficult transition. For example, a study on communicative behaviors of Vietnamese cancer patients indicates that in the absence of symptoms, cancer is not relevant to Vietnamese immigrants despite being told the harms of its future manifestation (Nguyen, Barg, Armstrong, Holmes & Homik, 2007). Similar observations were found in a study on Vietnamese diabetic patients done by Mull, Mull, and Nguyen (2001).

Other cultural influences on healthcare perceptions have been explored by Jenkins, Le, McPhee, Stewart, and Ha (1996). Their results yield a significant number of Vietnamese immigrants using traditional medical practices and believing in traditional Chinese medicine as an explanatory model for disease. However, no correlation is found between these beliefs and practices and underutilization of primary care. As in Khuu's (1998) and McPhee's (2002) articles, the Jenkins et al. study (1996) identifies poverty as the main predictor of health care access. Some interviewees in another study express a preference for traditional practices over Western practices (Houston, 2002). They also refrain from telling their physicians about their use of traditional practice because they fear that physicians would look down upon them. No studies have attempted to reveal whether or not Vietnamese patients place their alternative remedies above their physicians' recommendations.

The previously mentioned studies also allude to communication styles exerted by Vietnamese patients in the healthcare context. For example, one of their common communicative behaviors is authority questioning avoidance (Khuu, 1998). The Vietnamese cancer patients studied by Nguyen et al. (2007) often assumed passive roles in their physician-patient interactions. They avoided asking their physicians for explanations of their health conditions and procedures. This behavior may be influenced by the exertion of high context communication or the very high regard and trust they typically have in their physicians (Houston, 2002; Ngo-Metzger et al., 2003). The collectivistic nature of the Vietnamese culture is demonstrated by the patients' family members who assist the patients in overseeing the patients' healthcare routines and overcoming communicative restraints such as limited health literacy and low English proficiency (Mull et al., 2001).

Data from a recent study highlights the mental and physical stress of the Vietnamese community in Post-Katrina New Orleans (Chen et al., 2007). Individuals who identified themselves as both a Vietnam War refugee and a Hurricane Katrina refugee were most likely to report having poor health status. The researchers found that low acculturation correlated with poorer health statuses and higher levels of post-traumatic stress disorder symptoms. Other factors contributing to the poor health status were discrimination, poverty, and stress resulting from recovery. There are currently no studies on how the New Orleans Vietnamese community copes with its post-Katrina stress, whether or not they seek help from their physicians, or how the stress

affects communication with their physicians. As stated earlier, the present study explores members of this community and their personal healthcare experiences.

Three important themes explaining the Vietnamese population in the United States emerge from these studies. First, low ratings of healthcare encounters from Asian groups, including the Vietnamese as a subgroup in the United States are prevalent among quantitative studies. Secondly, qualitative studies provide evidence for low acculturation, low English proficiency, and low health literacy, which all serve as communication barriers that may account for the low healthcare ratings. Third, the studies highlight behaviors and practices influenced by culture such as the use of traditional medicine, passivity, and authority questioning avoidance. However, there are currently no studies that directly relate these communicative behaviors to proposed communication theories. Hence, this study proposes the following research question:

RQ: How does the collectivistic dimension of cultural variability induce the use of conversational constraints in the communication practices of Vietnamese immigrants during their interactions with physicians?

## **Method**

### *Participants*

The sample consisted of 12 Vietnamese immigrants living in the New Orleans metropolitan area. Five of the participants were male and seven were female. The age range was 47-80 years with a mean of 65 years. The range for the amount of years spent in the United States was 10-40 years with a mean of 22 years. Four of the participants were originally from North Vietnam, three from Central Vietnam, and five from Southern Vietnam. Four of the participants were Catholic and eight were Buddhists; all were active at their respective place of worship. Seven out of 12 participants did not finish elementary school. Six out of 12 knew little or no English.

### *Procedure*

Subjects for the study were selected based on a purposive sampling method. Since the subjects were initially contacted through family and friends, rapport was readily established between the researcher and the interviewees. The older Vietnamese immigrant population was of interest because previous studies have shown that they tend to be less acculturated, less health-literate, and more traditional (Australia Association for Research and Education, 2005; McPhee, 2002; Nguyen et al., 2007).

Over a span of three weeks, 20-30 minute semi-structured interviews were given to volunteer interviewees. Before each interview, the participants signed a consent form, orally translated in Vietnamese, to acknowledge their understanding of the nature of the study. To avoid language barriers, the interviews were conducted in Vietnamese. The interview-style approach provided an open-ended means for sharing thoughts and experiences. Six of the interviews were conducted in person in the participant's home, and six interviews were conducted over the phone at the participant's convenience because they deemed the condition of their homes to be unsuitable for visitors at the time.

Only four interviewees' permitted the audio recording of their interview session. The other interviewees believed that their personal and confidential thoughts would be inhibited by the recording process. After living in a communist country for much of their lives, some were not accustomed to publicly voicing their full opinions. They also conceptualize any type of recording as a form of mass media because they are generally unfamiliar with the use of this type of technology for personal use. In order to maintain the participants' confidentiality, all audio recordings (with the exception of three permitted audio samples) are accessible only to the researcher.

### *Instrument*

Building on previous findings about the healthcare of Vietnamese immigrants, the researcher developed a questionnaire pertaining to the conversational style of Vietnamese in relation to their interactions with their physicians (with an emphasis on non-Vietnamese physicians). The questionnaire consisted of 20 questions organized into four main categories (Appendix A and Appendix B). The first category included five demographic questions. The responses were initially recorded with a 5-point Likert-type scale. However, the participants did not understand the scale. Therefore, the researcher used percentages, a response format more familiar to Vietnamese people in general. Examples of demographic questions were: "How long have you been in the United States?", "What is your highest educational level?", and "How comfortable are you with your English proficiency?" The second category of questions pertained to the respondent's beliefs and attitudes towards health and included items such as preference for the concordance of physician-patient ethnicity and rating of perceived personal health status. The six questions in this category included the following examples: "Do you regularly see a primary care physician?" and "Do you speak to your physician one-on-one or do you have family members or friends with you to communicate to your physician?" The third category consisted of two questions that inquired about the use of traditional medicine. Examples included, "Do you practice traditional medicine at home (such as coin rubbing and cupping)?" and "Has your primary physician ever asked you about Eastern traditional healing practices (if you engage in them)?" Finally, nine questions concerning conversational styles were asked in a fourth category that consisted of three sub-categories: comfort, clarity, direct/indirectness. Examples of these questions were: "To what extent are you comfortable with giving input to your conversations with your physician?" (comfort), "When you are unsure of what your physician is asking you, what do you do?" (clarity), "Have you ever shared or offered to share information about how you take care of your health with your physician?" (direct/indirectness), and "How do you respond to negative comments (not following a prescribed diet, for example) from your physician?" (direct/indirectness). Links to three audio samples of interviews are available here: sample one; sample two; sample three.

### **Results**

A theme analysis was performed on the collected data (Bormann, 1983). Themes frame representations of common experiences through a word or a sentence (Shields & Preston, 1985). The analysis revealed 22 themes (see Table 1). As indicated by their responses, the respondents' orientation to tasks over relationships displays the concern for clarity and effectiveness. The orientation to relationships over tasks is demonstrated by the respondents' avoidance of hurting the physician's feelings, concern for minimal imposition on the physician, and avoidance of negative evaluation from the physician.

Since seeking care from a physician is a task-oriented goal, clarity in this sense was important to all respondents, but it was not directly reflected in the respondents' communication style. They assumed that their physicians already knew that their main concern was to get treatment for their ailments. They all had a family member or friend accompany them mainly for major health problems. The two most educated participants asked for and received clear detailed information about their conditions (e.g. high blood pressure and osteoporosis) and procedures (e.g. screenings, blood tests, urine tests).

Concern for effectiveness was also present. Eight out of 12 respondents visited Vietnamese doctors in order to better communicate their health conditions and essentially receive a more personalized experience. However, many of them expressed less satisfaction with the quality of medical care from physicians trained in Vietnam in comparison to those trained in the United States. Only three out of 12 respondents offered to share information about how they maintained their health at home. Again, the degree of the concern was higher in the communication style of the more educated respondents as they stressed the importance of nonverbal facial expression in complementing their understanding of the physician's verbal comments.

When presented with a hypothetical problem, the respondents prioritized relationally-oriented goals over task-related goals. These problems included insufficient time spent by the physician to explain conditions and procedures, limited opportunities for the respondent to speak, and disagreement with the physician's diagnosis, mannerisms, treatment, etc. Only two of the respondents would question the physician, three would change physicians, and one would ignore the issue. The last two responses are communication strategies that stress the concern for avoiding hurting the hearer's feelings. The respondents especially felt obligated to comply with this constraint because they entrusted full autonomy of the relationship to the physician.

Several participants avoided asking questions because they did not want to take up too much of the physician's time. They only asked the physician to repeat information relevant to basic treatments, which was the participants' main concern. Few or no requests for elaborations were made on the nature of the medical condition, procedure, or treatment. Eleven out of 12 claimed to only speak when the physician asked them to. These findings, along with the low number of respondents who offered information about their lifestyle to their physicians, are all relevant to minimizing imposition on the physician's autonomy in the relationship.

To avoid negative evaluation from the non-Vietnamese physicians for their low English proficiency, half of the respondents visited Vietnamese primary care physicians or depended on family members with higher English proficiency to translate for them. All the respondents used traditional medical practices as first response remedies but did not inform their American physicians about it. Respondents who visited Vietnamese physicians assumed that the physicians already knew of their use of traditional practices. Those who visited non-Vietnamese physicians did not mention the practices to their physicians because either they found it to be irrelevant to the issue at hand or they did not want the physician to look down upon them. Since all respondents claimed to follow their physician's recommendations (despite contrary evidence



presented by family members or their own answers to other questions), no follow-up questions about the respondents' disclosure of non-compliance to the physician were asked.

Interestingly enough, more emphasis was placed on task-oriented goals than relationally-oriented goals during the interview with the researcher. To stress the importance of clarity, the respondents freely asked the researcher to repeat or clarify any questions that were unclear. Their enthusiastic tone of voice demonstrated their concern for getting their message across to the researcher. A few of the respondents freely criticized questions that they deemed irrelevant. For example, they believed that their level of comfort in interacting with their physicians was not an issue as long as basic treatment was prescribed. They also stated that emphasizing the quality of the consultation (i.e. factors such as the clarity of the physician's medical explanations or the patient's willingness to disclose information about their personal health lifestyle) only complicates matters and contributes nothing to the progress of medicine. Most of them also freely expressed any thoughts and/or evaluations of the interview process, no matter how negative they were. They also did not limit the content or the length of their responses.

## Discussion

The purpose of this study was to examine the influence of culture on the use of conversational constraints in the communication behaviors of Vietnamese immigrants when interacting with their physicians. The results of this study support the findings by Kim et al. (2000) that link collectivistic cultures to relational conversational constraints over task-oriented conversational constraints.

Three important findings emerged from this study. First, the respondents' reported conversational style that emphasized relational conversational constraints. To minimize imposition on the physician's autonomy in the consultation, they spoke only when asked questions by the physician and refrained from asking questions themselves due to perceived time constraints. The respondents' interdependent self construal directed them to place themselves beneath their physicians in terms of power. Most of them would handle problems with their physicians by ignoring the issue or changing physicians in order to prevent hurting the physician's feelings. To prevent negative evaluation, respondents refrained from informing non-Vietnamese physicians about their use of traditional medical practices. Interestingly, respondents with postsecondary education prioritized the task-oriented conversational constraint of concern for effectiveness over minimal imposition on the physician to receive more detailed medical information.

Second, respondents were more likely to exhibit task-oriented conversational constraints in indirect ways. For the sake of clarity and effectiveness, most respondents preferred to visit Vietnamese physicians because they felt that they could communicate their symptoms more clearly in their own language. They were likely to be more involved in the interaction, and they expected more detailed explanations about their conditions from Vietnamese physicians. Since Vietnamese specialists are rare, all respondents had visited non-Vietnamese physicians and had depended on more fluent and acculturated family members during those interactions. Asking third parties to assist during instances of major illnesses expressed the respondents' indirect desire for clarity and effectiveness. Finally, the role of self construal was clearly demonstrated by the difference in conversational style used by respondents when communicating with physicians

and the researcher. Since the researcher was perceived to be in a position of lower power than the respondents, they were less concerned with exerting relational conversational constraints.

Cultural variability was examined through three different lenses to detect its influence on communication. In the broadest view, this study investigated the communication behaviors of a traditionally collectivistic culture living within an individualistic society. A narrower view focused on the five components of conversational constraints theory and its influence on communication styles. The last view showed how the concept of self construals determined which constraints were reflected through behaviors during specific contexts. Understanding how cultural variability influences communication practices of culturally-diverse patients helps physicians improve the quality of their relationships with their patients and subsequently the comprehensive quality of their care.

#### *Limitations and Implications for Future Research*

This study has several limitations. First of all, the sample size was relatively small. A larger sample size would allow for the detection of more common themes from the responses. The interview questions were too general at the time to elicit in-depth responses, in spite of the researcher's follow-up questions. A suggested approach would be to ask the participants to tell personal stories beginning with their current health status and latest health interactions to elicit spontaneous rendering of their experiences with their physicians. Another limitation of the study was the subjects' cultural bias against social scientific research because some participants found it to be a trivial Western invention. A brief introduction to the significance of communications research prior to the interview may alleviate this bias.

Since the findings were based only on the subjects' perceptions, future studies may include perceptions of family members active in the subjects' healthcare maintenance and perceptions of the subjects' physician. As a collective group of people, individuals within one's in-group may also influence the nature of one's acculturation and possibly language and health literacy as well. Levels of acculturation are of interest to future researchers because Vietnamese individuals vary on what aspects of American culture they choose to incorporate into their lives. For example, Vietnamese immigrants who associate more with second generation Vietnamese Americans in the healthcare field may adopt more Western traditions and beliefs about healthcare than those who are more grounded in tradition and see the adoption of new beliefs to be an abandonment of their cultural roots. Further implications for research may also be expanded to include other theories of cultural variability such as face negotiation, expectancy violations, and anxiety/uncertainty management, all of which are pertinent in assessing the quality of communication within the countless culturally diverse physician-patient relationships present in the United States.

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### Acknowledgements

I would like to thank my family, mentors, and interviewees, all of whom took part in this inspirational experience. My family immerses me in their everyday medical experiences, which allows me to make many cross-cultural observations that I am able to further analyze in my communications coursework. I received my first taste of communications research through a literature review assignment on perceived disparities in cross-cultural physician-patient relationships from an intercultural communications course dynamically instructed by Dr. Ross

Louis, Ph.D. Shortly after, Dr. Dominique Gendrin, Ph.D. took me under her wings and provided me with exceptional guidance and motivation throughout the progression of this project, which further developed my understanding of the intriguing combination of intercultural and health communication. I am also deeply appreciative of all the participants, who wholeheartedly shared their time and personal stories with me during the interviews. Their contribution to this project will ultimately help physicians to improve communication with their patients and to understand them better. Finally, I would like to knowledge Xavier University of Louisiana and its Communications Department for providing the medium for this enriching opportunity.

## Appendix A

### Interview Questions (English)

#### *Demographics*

1. How old are you?
2. How long have you been in the United States?
3. What is your highest education level?
4. How well do you think Americans understand you when you speak English? (very well, well, ok, not too well, not well at all)
5. How well do you think you understand native English speakers? (very well, well, ok, not too well, not well at all)

#### *Beliefs and Attitudes towards Health*

6. How would you rate your current overall health condition? (excellent, good, average, fair, poor)
7. To what extent does recovery from Hurricane Katrina impact your current condition? (very strong, strong, average, some, no impact)
8. Do you regularly see a primary physician? (yes/no)
9. Do you see a Vietnamese physician? (yes/no)
  - a. If yes, then why?
  - b. If no, then what is your physician's ethnicity?
  - c. If you had the opportunity, would you rather see a Vietnamese physician? (yes, not sure, no)
10. Do you speak to your physician one-on-one or do you have family members or friends with you to communicate with your physician?
  - a. Why or why not?

#### *Traditional Medicine*

11. Do you practice traditional medicine at home (such as coin rubbing and cupping)?
12. Has your primary physician ever asked you about Eastern traditional healing practices (if you engage in them)?

#### *Conversational Style in the Primary Healthcare Context*

13. Have you noticed any differences in how your physicians here in America talk to you versus those you have visited in Vietnam? If so, please explain.
14. How comfortable do you feel around your physician during a consultation? Please explain.
15. To what extent are you comfortable with giving input to your conversations with your physician? (comfortable, no opinion, not comfortable) Please explain.
16. Have you encountered obstacles in getting your physician to understand what you want to say?
  - a. For example:
    - i. Your physician does spend enough time to explain
    - ii. Your physician does allow you enough time to speak

- iii. You disagree with your physician (in his diagnosis, mannerisms, treatment, etc.)
  - b. If yes, then what do you do?
17. When you are unsure of what your physician is asking you, what do you do? Please explain.
  18. Have you ever shared or offered to share information about how you take care of your health to your physician? Why or why not?
  19. In your conversations with your physician, do you only speak when you are asked to?
  20. When doctors give you recommendations and drug prescriptions, do you usually follow only those orders, follow the orders along with traditional remedies or ignore them all together?



## Appendix B

### Câu Hỏi Phỏng Vấn (Vietnamese)

#### *Tài Liệu Bản Thân*

1. Thưa ông/bà, năm nay ông/bà được bao nhiêu tuổi?
2. Ông/Bà sống ở Mỹ được bao lâu?
3. Thưa ông/bà, trình độ học vấn của ông/bà được đến cấp mấy?
4. Khi ông/bà nói tiếng Anh, ông/bà nghĩ người Mỹ hiểu được bao nhiêu phần trăm?
5. Ông/Bà hiểu được bao nhiêu phần trăm tiếng Anh khi người Mỹ nói chuyện với ông/bà?

#### *Sức Khỏe Cá Nhân*

6. Ông/Bà nghĩ thế nào về sức khỏe của ông? (tốt, bình thường, không tốt)
7. cơn bão Katrina có ảnh hưởng gì đến sức khỏe tâm lý cũng như thân thể của ông/bà không?
8. Ông/Bà có đi khám sức khỏe thường xuyên không?
9. Ông/Bà có đi khám bác sĩ Việt Nam không?
  - a. Nếu có, tại sao?
  - b. Nếu không, thì bác sĩ ông/bà là người gốc gì?
  - c. Nếu ông/bà có cơ hội thì ông/bà có đi khám bác sĩ Việt Nam không?
10. Khi đi viếng bác sĩ, có ai đi chung không? Người đó là ai? Vì sao người đó đi theo?

#### *Đông Y*

11. Ở nhà, ông/bà có sử dụng phương pháp của ĐôngY không? (thí dụ như cạo gió hoặc giác hơi)
12. Ông/Bà có cho bác sĩ hay là ông/bà sử dụng những phương pháp đó không? Tại sao?

#### *Cách Đàm Thoại*

13. Ông/Bà có thấy gì khác về cách đối thoại giữa bác sĩ ở Mỹ và bác sĩ ở Việt Nam không? Tại sao?
14. Ông/Bà có cảm thấy thoải mái khi nói chuyện với bác sĩ ở Mỹ không?
15. Ông/Bà có hỏi về chi tiết của tình trạng của ông/bà không?
16. Giữa ông/bà và bác sĩ, có sự trở ngại gì khi bác sĩ nói chuyện với ông/bà không?
  - a. Thí dụ như sao:
    - i. Bác sĩ không để ra đủ thì giờ để giải thích tình trạng
    - ii. Bác sĩ không để ra đủ thì giờ để ông/bà trả lời câu hỏi
    - iii. Ông/Bà bất đồng ý với bác sĩ
  - b. Nếu có, thì ông/bà làm thế nào?
17. Nếu ông/bà không hiểu bác sĩ hỏi gì, thì ông/bà làm thế nào?
18. Có khi nào ông/bà cho bác sĩ biết cách giữ gìn sức khỏe của ông/bà không?
19. Ông/Bà chỉ trả lời khi bác sĩ hỏi ông/bà, có phải vậy không?
20. Khi bác sĩ cho ông/bà ý kiến hoặc toa thuốc, ông/bà có làm đúng theo không?

**Table 1***Conversational Constraints Themes*

Categories	Themes
Beliefs and Attitudes about Health	(1) Fair or average health rating, (2) preference for concordance of physician-patient ethnicity for language reasons, (3) dissatisfaction in quality of care from physicians trained in Vietnam, (4) more trust in American-trained physicians since they follow more rigorous standards, (5) reasons for physician visits include only serious ailments and routine check-ups required for employment purposes, (6) family member accompaniment to translate or give support during healthcare visits, (7) variable mental and physical impact from Hurricane Katrina
Traditional Medicine Use	(1) Preference for traditional remedies over Western medicine as first response to ailments, (2) no disclosure of use to physicians since physicians do not inquire about use, (3) fear of negative evaluation from non-Vietnamese physicians because of their presumed unfamiliarity with Eastern medical practices
Conversational Style	Themes
Comfort	(1) More active participation in interactions with Vietnamese physicians because of language concordance, (2) non-Vietnamese primary care physicians express more politeness, (3) generally high comfort level in physician encounters regardless of ethnicity
Clarity	(1) Younger family members with more English fluency speak for patients with little or no fluency, (2) requests for repeating information only made when the treatment (most pertinent information) is not heard clearly, (3) self-interpretation of less pertinent information when unclear, (4) avoidance of physicians preferred over confrontation as a response to dissatisfaction in a medical encounter, (5) few or no requests for elaborations on medical condition, procedures and treatment
Directness	(1) Personal health lifestyle only shared when prompted

Indirectness	(1) Full autonomy of the relationship entrusted in the physician and his/her expertise, (2) little or no input given or questions asked because of perceived constraints on the physician's time, (3) identification of good physicians by more exaggerated facial expressions and slower speech to better communicate messages during the consultation
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*Note:* Little information was gathered for “directness” because the correlating questions were too direct and implied a negative view (i.e. a hypothetical physician confronts a patient for ignoring or neglecting orders) towards the patient.